

MDR Tracking Number: M5-02-1926-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on all the issues of medical necessity. The IRO agrees with the previous determination that additional physical therapy from 05-15-01 through 6-28-01 were not medically necessary. The IRO disagrees with the previous decision to deny the 5-7-01 office visit. It was medically necessary for the patient to undergo a medical examination related to his injury.

Based on review of the disputed issues within the request, the Division has determined that medical necessity was the only issue to be resolved. The additional physical therapy was not found to be medically necessary for dates of service 5-15-01 through 6-28-01, but the office visit was found to be medically necessary for date of service 5-7-01.

On this basis and pursuant to Sections 402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order. This Order is applicable for date of service 5-7-01 through 5-7-01 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307 (j)(2)).

This Order is hereby issued this 29th day of April 2002.

Dee Z. Torres, Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

IRO Certificate #4599

Amended NOTICE OF INDEPENDENT REVIEW DECISION

February 21, 2002

Re: IRO Case # M5-02-1926-01

Texas Worker's Compensation Commission:

___ has been certified as an Independent Review Organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment is not medically necessary. Therefore, ___ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

I agree with the carrier's decision to deny this patient the requested therapy 5/7/01 –6/28/01. Group sessions could have served this patient just as well, and may have been more therapeutic. It is questionable whether the extensive use of therapeutic sessions was medically necessary at all, when the passage of time may have been just as helpful for this patient. This is especially true in a case such as this case in which there is nothing in the way of objective diagnostic testing that shows a distinct abnormality to be treated.

I disagree with the carrier's decision to deny a 5/7/01 office visit. It was medically appropriate for the patient to undergo a medical examination related to his injury.

This medical necessity decision by an Independent Review Organization is deemed to be a

Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of proceedings, Texas Worker's Compensation Commission, P O Box 4066, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,